X2015-1315

PRINTED: 08/11/2015
FORM APPROVED

Washington State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY This State hospital licensing survey was conducted 7/21/2015 - 7/23/2015 by Lisa Sassi, RN, MN and Alex Giel, REHS, PHA. Joyce Williams, RN, BSN participated as an orientee. The Washington Fire Protection Bureau conducted the fire life safety inspection on 7/21/2015. ASE #DN1P11 BHC Fairfax Hospital(Psychiatric) HAC. FS. 00000004	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and, if monitoring, what are the benchmarks to assure continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked August 28, 2015. 4. Return the ORIGINAL REPORT with the required signature(s) on the first page.	
L 355	322-035.1K POLICIES-STAFF ACTIONS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (k) Staff actions upon: (i) Patient elopement; (ii) A	L 355		

By signing, I understand these findings and agree to correct as noted:
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 8/26/15

Received 8.28.15 Hsu

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 355	Continued From Page 1 serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This WAC is not met as evidenced by: Based upon observation, interview and review of policy and procedure, the facility failed to implement patient incident reporting. Findings: 1. In review of facility policy titled, "Incident Reporting: Healthcare Peer Review (HPR) Occurrence Reporting System" (Reviewed/Revised 4/15) under the "Definitions" section it stated, "Occurrence (Incident Type): that which is not consistent with the routine care of a patient and/or the desired operations of the facility. The results of this event require or could have required (near miss) unexpected medical intervention...or had the potential to cause an unexpected physical or mental impairment." In the section B on page 1 it listed examples of Serious Injuries/Event which included "Injury/Physical harm to patients..." On page 3 under the "Procedure" section it stated, "Any facility employee or staff member who discovers, is directly involved in or is responding to an event/occurrence is to complete or direct the completion of a Healthcare Peer Review (HPR) form. This form is referred directly to the facility Risk Manager within 72 hours of completion." The timeline for staff completion of the form was designated under Item C.a. as to occur "at the	L 355		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 355	Continued From Page 2 time of the event". 2. On 7/22/2015 between 1:30 and 2:30 PM while on a tour of the 1 North unit Surveyor #1 interviewed the environmental services manager (Staff Member #10) and the administrative Staff Coordinator (Staff Member #11) about patient access to the locked laundry room. Both staff members indicated that it was considered off-limits for unsupervised patient access. 3. On 7/22/2015 between 1:30 PM and 2:30 PM Surveyor #1 observed Patient #3 exit a locked laundry room by her/himself (no staff member present). The patient asked the surveyor if her/his own head was bleeding. The surveyor noted that the patient had a scalp wound that was bleeding. The patient was then escorted to facility staff for attention to the bleeding wound. 4. On 7/23/2015 at 2:00 PM Surveyor #2 inquired about whether an incident report had been submitted by staff for the event that occurred involving Patient #3. The facility staff were unable to locate a report. At that time the Chief Nursing Officer (Staff Member #5) stated that s/he did not think the event should generate a need for an incident report. Then s/he stated that the lack of direct patient supervision while present in the laundry room should have at least generated an incident report.	L 355		
L 415	322-035.2 P&P-ANNUAL REVIEW WAC 246-322-035 Policies and Procedures. (2) The licensee shall review and update the policies and	L 415		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 415	Continued From Page 3 procedures annually or more often as needed. This WAC is not met as evidenced by: Based on review of policy and procedure, the facility failed to assure that policies and procedures were reviewed and updated at least annually. Findings: 1. In review of policy and procedure titled, "Developing and Implementing Policies and Procedures" (Revised 5/2013) on page 2 under section A.1. it stated, "All policies are reviewed by the Department Heads on an annual basis and brought to the appropriate committee for full review and approval on an annual basis". 2. In review of the following policies and procedures it was noted that the review date did not occur within the past 12 months: Patient Rights and Organizational Ethics (04/05); Patient Rights to Care and Treatment (04/04); Admission Procedures and Triage of Patients with Potentially Transmissible Infections (03/2014); Major Medical Emergency Treatment (January 2014); General Health/Emergency (January 2014); Patient Elopement (January 2014), Abuse Assessment and Reporting (05/2014) and Patient Death/Suicide (January 2014).	L 415		
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which	L 690		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 690	Continued From Page 4 Includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This WAC Is not met as evidenced by: Based on observation, interview and review of policy and procedures, the facility failed to ensure disinfection activities to prevent and control infections. Item #1 Hand Hygiene Findings: 1. In review of facility policy titled, "Medication Administration" (Revised 8/2014) on page 2 under item 4.b.ii. it stated, "The licensed nursing staff will use proper hand washing techniques prior to handling medication for administration." Further specifics related to handling medications were not included. Information about hand hygiene related to medication administration was not included in the facility policy titled, "Hand Hygiene" (Revised 3/2014). 2. On 7/21/2015 at 9:20 AM a nurse (Staff Member #1) was observed administering medications to Patient #1 and Patient #2. The system for medication administration included patients coming to a designated window at the nurse's medication room to obtain the medication. The medication nurse did not perform hand hygiene after doing tasks in the medication room and prior to initiating access to medications from electronic medication storage unit. The nurse did not perform hand hygiene after medication administration to Patient #1 (including, but not	L 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 690	Continued From Page 5 limited to, handling a paper cup filled with water used by the patient during medication administration) and prior to proceeding to Patient #2. At that time the nurse acknowledged that s/he did not perform hand hygiene prior to handling patient's medications. Item #2 - Cleaning Patient Care Equipment Reference: CDC Centers for Disease Control and Prevention: Infection Prevention during Blood Glucose Monitoring and Insulin Administration (Rev date 2/6/2013) page 6 under Blood Glucose Meters stated in part: "If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be used". Reference: In review of the One Touch Ultra Mini User Guide (Rev date: 07/2009) on page 20 it provided a section on "Caring for your system." it stated in part, "To clean your meter, wipe the outside with a soft cloth dampened with water and mild detergent. Do Not use alcohol or another solvent to clean your meter". Findings: 1. In review of the hospital's policy and procedure titled, "Cleaning Agents Selection" (Revised 10/2014) on page 2 it stated, the disinfectant agent to be used on glucometers was a 1:10 bleach wipe solution and the frequency was "after each use and daily." In the same policy on page 3 it stated, "the vital signs machine should be wiped down after each use, using a bleach wipe."	L 690		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 690	Continued From Page 6 2. On 7/22/2015 between the hours of 9:30 and 10:30 AM Surveyor #1 observed an LPN (Staff Member #13) remove a blood pressure cuff from a patient arm and place the vital signs machine behind the nurse's station without disinfecting the machine. 3. On 7/21/2015 at 11:45 AM Surveyor #1 interviewed a LPN (Staff Member #12) about the routine use of glucometers for testing patient blood sugars. S/he described the testing process and stated that after using the glucometer s/he would wipe down the meter with a "Sani Hand Wipe" (an alcohol based product; not bleach wipes). 4.On 7/23/2015 at 12 PM, Surveyor #3 observed a medication nurse (Staff Member #8) on 2 West perform a blood sugar check on Patient #5 who was an insulin-dependent diabetic. Upon completion of the blood sugar check, s/he cleaned the glucometer with an alcohol wipe. S/he stated that normally the glucometer would be cleaned with a bleach wipe but the facility had been out of bleach wipes for a couple of days. 5. On 7/22/2015 at 8:30 AM during a tour of Central Unit, Surveyor # 3 interviewed a medication nurse (Staff Member #9) about the procedure for cleaning glucometers upon completion of blood sugar checks on insulin dependent patients. S/he stated that glucometers were cleaned between patient uses with bleach wipes. S/he noted that bleach wipes had not been available in the facility for a couple of days and therefore s/he used an alcohol wipe instead.	L 690		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 690	Continued From Page 7 Item #3 - Adequacy of a Product Used to Disinfectant Equipment Findings: On 7/21/2015 at 11:45 AM Surveyor #1 interviewed an LPN (Staff Member #13) about the process of disinfecting glucometers. The staff member identified that s/he used Sani-Hand Wipes. It was determined at that time that the alcohol content in "Sani Hand Wipes" was 65.9% (below adequate concentration for disinfection).	L 690		
L 695	322-100.1B INFECT CONTROL-REVIEW *WAC 246-322-100 Infection Control.* The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (b) A review process, using definitions and criteria established by the infection control committee, to determine if staff and patient infections are nosocomial; This WAC is not met as evidenced by: Based on interview, the facility failed to establish and implement an effective hospital-wide infection control program, which included a review process, using definitions and criteria established by the infection control committee, to determine if staff and patient infections were nosocomial. Findings: On 7/23/2015 at 1:30 PM during an interview between Surveyor #2 and the Medical Director of	L 695		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 695	Continued From Page 8 Infection Prevention (Staff Member #6), s/he acknowledged that the facility had not established a process to determine whether staff and patient infections were nosocomial. The facility had initiated defining a process during an infection outbreak in April 2015 but a formal process had not been developed to-date.	L 695		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This WAC is not met as evidenced by: Based on observation, document review, and review of hospital's policy and procedures, the hospital failed to provide a safe and clean environment for patients. Item #1 Off Limit Areas Findings: 1. In review of the hospital's policy and procedure titled, "Patient Observation Policy" (Effective Date 5/2011), step"G." stated the following, "While monitoring hallways and patient care areas ensure patients are: not in rooms or areas that are designated "off limits" areas to patients." The policy did not identify which areas were considered "off limits." 2. On 07/22/2015 between the hours of 1:30 PM and 2:30 PM, Surveyor #1 observed Patient #3 come out of the laundry room in the North unit.	L 780		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 780	Continued From Page 9 The patient came up to the surveyor and asked if s/he was bleeding on the top of her/his scalp. Surveyor #1 observed blood ooze from a scrape on Patient #3's scalp and the surveyor asked how the incident occurred. The patient stated in part, that s/he hit her/his head on the "dryer door" in the laundry room. Surveyor #1 asked if patients can be in the laundry room unsupervised (as the patient was). The environmental service manager (Staff Member #10) replied in part, "The laundry room is considered off limits to patients". The administrative Staff Coordinator (Staff Member #11) confirmed that the laundry room was considered an "off limits" area. Item #2 Clean Environment Findings: 1. In review of the contractual agreement with "Open Works" (the environmental services provider) on page 5 of the work schedule it stated, "to wash/wipe down walls as needed to remove spots, 7 days a week". 2. On 7/21/2015 at 10:15 AM Surveyor #1 observed a housekeeper (Staff Member #15) clean a patient room (room #117) on the North unit. The housekeeper did not clean the pencil markings along the patient's wall. 3. On 7/21/2015 at 10:30 AM Surveyor #1 observed holes in the wall in patient's bathroom (for room #139) on the North unit. The toilet paper dispenser was removed leaving several holes in the dry wall. 4. On 7/21/2015 at 1:30 PM Surveyor #1 observed graffiti all over the walls in room #708 on West 1 unit. This was confirmed by the Chief Operating	L 780		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 780	Continued From Page 10 Officer (Staff Member #14). Item #3 - Safe Environment: Findings: On 07/21/2015, between the hours of 2:00 PM and 3:00 PM, Surveyor #1 observed an "L" shape plumbing fixture (backflow prevention device) protruding from the wall inside the laundry room on the East unit (adolescent unit). The fixture was on the right side above door frame. A soiled linen container with the lid down was positioned underneath the fixture allowing access. The fixture was also not in plain sight of the viewing window to the laundry room. The plumbing set-up provided a potential risk for ligature harm.	L 780		
L 880	322-140.1i ROOM FURNISHINGS WAC 246-322-140 Patient living areas. The licensee shall: (1) Provide patient sleeping rooms with: (i) Sufficient room furnishings maintained in safe and clean condition including: (i) A bed for each patient at least thirty-six inches wide or appropriate to the special needs and size of the patient; (ii) A cleanable, firm mattress; and (iii) A cleanable or disposable pillow; This WAC is not met as evidenced by: Based on observation, document review and review of hospital's policies and procedures, the hospital failed to provide a safe and clean environment for its patients. Findings:	L 880		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 880	Continued From Page 11 1. In review of the hospital's policy and procedure titled, "Bed Making" (Effective Date 01/2000), Contributors: Infection Control Committee; "Purpose: The surveillance, prevention and control of infection". The policy lacked actual procedures for surveillance of beds and infection control measures to prevent infection transmission from beds. The policy only identified how to make a bed. 2. In review of hospital's contractual agreement with "OpenWorks" (the environmental services provider) on page 8 under "Patient Discharge/Move" it stated, "to sterilize mattress as needed". 3. On 7/21/2015 between the hours of 10:00 AM and 3:00 PM during a tour of the facility Surveyor #1 observed 6 of 12 torn patient mattresses. This was confirmed by the Chief Operating Officer (Staff Member #14). During the same time Surveyor #1 observed food debris underneath the mattress in room #710 on the West 1 unit.	L 880		
L1165	322-180.2 EMERGENCY SUPPLIES WAC 246-322-180 Patient Safety and Seclusion Care. (2) The licensee shall provide adequate emergency supplies and equipment, including airways, bag resuscitators, intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff. This WAC is not met as evidenced by:	L1165		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1165	Continued From Page 12 Based on observation, interview and policy and procedure review, the facility failed to assure the availability and use of intravenous solutions as a part of emergency supplies. Finding: 1. On 7/21/2015 at 2:00 PM during a tour of the 1 North nursing station, Surveyor #2 noted that intravenous solutions were not located in the unit's medical emergency supply bag. The surveyor asked a nurse (Staff Member #2) about the availability of intravenous fluids for administration in the event of a patient medical emergency. S/he stated that intravenous fluids were not available for patient care. This finding was confirmed on 7/22/2015 at 2:00 PM in a follow-up interview with a facility pharmacist (Staff Member #3) related to the facility in general. 2. In review of policies titled, "General Health/Emergency (Reviewed/Revised: January 2014) and "Major Medical Emergency Treatment" (Reviewed/Revised: January 2014), it was noted that the procedures did not address the securing or use of emergency medical supplies for patient care in medical emergency situations.	L1165		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This WAC is not met as evidenced by: Item #1 - Food Storage	L1485		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1485	Continued From Page 13 Based on observation and interview, the facility failed to assure that food storage code 246-215-03351 and 2009 FDA Food Code 3-305.11 were adhered to. Findings: 1. On 7/21/2015 at 2:00 PM during a tour of the 1 North nursing station, Surveyor #2 noted that boxes containing patient food items were located on the floor of the nursing station. The food items for distribution included tea, popcorn and oatmeal. During that time period, the charge nurse (Staff Member #4) acknowledged that food items were located on the floor due to storage space limitations in the nurses' station. Reference: WAC 246-215-03351; Preventing contamination from the premises-Food storage (2009 FDA Food Code 3-305.11). (1) Except as specified in subsections (2) and (3) of this section, FOOD must be protected from contamination by storing the FOOD: ...(c) At least six inches (15 cm) above the floor. Item #2 - Food Debris Based on observation, the facility failed to comply with chapters 246-215, Washington Administrative Code (WAC) for food service. Findings: 1. On 07/22/2015 at 11:00 AM Surveyor #1 observed food debris accumulation on a meat slicer intended to be ready for use. 2. On 07/22/2015 at 11:15 AM Surveyor #1	L1485		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1485	Continued From Page 14 observed food debris on a clean knife and the knife was stored in a soiled knife rack. Reference: Washington State Retail Food Code, WAC 246-215-04600(1) 3. On 07/22/2015 at 11:30 AM Surveyor #1 observed severe accumulation of residue growing inside the juice dispenser. To prevent contamination of product, the unit must be cleaned to preclude accumulation of soil residue. Reference: Washington State Retail Food Code, WAC 246-215-5605(5)(d)	L1485		
L1490	322-230.2A FOOD SERVICE-24-HR MANAGER WAC 246-322-230 Food and Dietary Services. The licensee shall: (2) Designate an individual responsible for managing and supervising dietary/food services twenty-four hours per day, including: (a) Incorporating ongoing recommendations of a dietitian; This WAC is not met as evidenced by: Based on review of the medical record and interview, the facility failed to ensure that dietary recommendations were incorporated into the patient's dietary plan. Findings: 1. In review of the medical record of a 14 year old patient (Patient #4) admitted on 4/8/2015 for treatment of severe recurrent psychotic depression, suicidal ideation and abdominal pain, it was noted that the patient had a dietary consult completed on 4/9/2015. The consult was provided	L1490		

By signing, I understand these findings and agree to correct as noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1490	Continued From Page 15 because the patient had an eating disorder and was anorexic. The dietician made specific recommendations about modifications for breakfast and lunch dietary intake to address the eating disorder and daytime anorexia. The patient was discharged on 4/17/2015. In review of the medical record there was no indication that the recommendations had been incorporated into the patient's care; including, but not limited to, the multidisciplinary care plan. 2. In a follow-up interview between the dietician and Surveyor #2 on 7/23/2015 at 2:30 PM, she indicated that there was not a policy and procedure that addressed how dietary consults were managed, including incorporation into the patient's plan of care. The dietician stated that s/he did not have a practice of making clinical entries into the multidisciplinary treatment plan. S/he stated that s/he thought the nursing staff spoke to the attending provider(s) about recommendations completed by the clinical dietician.	L1490		

By signing, I understand these findings and agree to correct as noted: